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ABSTRACT

A day care director of a center sponsored by a metropolitan medical center designed and implemented a practicum study to address the lack of a system for identifying and assessing high-risk children. The practicum was also intended to develop a program which would respond to teachers' concerns for children with special needs and obtain positive endorsements from teachers at the center. Registration forms were revised to include health and developmental information provided by parents. A new screening instrument was reviewed, selected, and implemented in student evaluations. A reference manual was compiled for center staff. The manual provided guidelines for step-by-step responses to students with problems. The manual also included lists of behaviors suggesting special needs status, of behavioral and developmental signs of high risk, and of resources for children; documentation strategies; conference recommendations; and parental release forms. Evaluation data indicated a favorable response to the project on the part of the center staff. There was an increase in the percentage of children's evaluations completed. A committee of parents and hospital personnel determined that the project had yielded a plan that would identify and provide follow-up services to children who might be at-risk. Related materials, such as the manual, registration form, and survey forms, are appended. (RH)

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Providing Identification, Assessment, And Resources For Potentially At-Risk Children Ages Two Months To Five Years Attending A Hospital Based Child Care Center

by

Kathleen Toigo

Conort XXVII

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A Practicum Report Presented to the National Master's Program for Child Care Administrators in Partial Fulfillment of the Requirements for the degree of Master of Science

Nova University

1989

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I hereby testify that this paper and the work it reports are entirely my own. Where it has been necessary to draw from the work of others, published or unpublished, I have acknowledged such work in accordance with accepted scholarly and editorial practice. I give testimony freely, out of respect for the scholarship of other workers in the field and in the hope that my own work, presented here, will earn similar respect.

10/11/89
Date

Kathleen A. Jones
Signature of Student

Abstract

Providing Identification, Assessment, And Resources For Potentially At-Risk Children Ages Two Months To Five Years Attending A Hospital Based Child Care Center. Toigo, Kathleen A., 1989: Practicum Report, Nova University, Master's Program for Child Care Administrators. Descriptors: Educational Diagnosis/Screening Tests/Ability Identification/Informal Assessment/Early Childhood Education/Developmental Difficulty/High Risk Persons/Consultation Programs/Referral

Because no effective system existed at the Child Care Center to evaluate and assess the children enrolled - and thereby identify those children potentially at-risk for developmental delays, learning difficulties or behavior problems - these children might not be identified. In addition, there was no comprehensive plan to combine evaluation and assessment with a resource network to validate concerns, offer further evaluation, and provide assistance in meeting the needs of these children.

The author revised registration forms to include important health and developmental information provided by parents. In addition, the author facilitated review, selection, and implementation of a new screening instrument to be used to evaluate children at the Center. This process, extending over an eighteen week period, consisted of gathering information, staff meetings for the purpose of discussion and selection, two training sessions, a monitored interval for use of the instrument, and a follow-up survey. The author also compiled a reference manual for Center staff which provided guidelines for step by step response to a teacher's concerns about a child in his/her case. The manual included documentation strategies, conference recommendations, parental release forms, and lists of resources for assistance in validating teachers concerns and in providing additional assessment and treatment services to children.

Surveys indicated a favorable response to the project on the part of the Center Staff. There was an increase in the percentage of children's evaluations completed. A committee of parents and hospital personnel determined that the outcome of the project constituted a plan in place that would identify and provide follow-up services to children who might be at-risk.

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Chapter 1

INTRODUCTION

The practicum setting is a child care center sponsored by a metropolitan medical center for use by its employees. All medical center employees from all hospital departments are eligible to use the services of the Center. The Center is licensed to the hospital, but the management of the child care facility and the employees of the child care center are under the control and direction of a separate entity - a corporation contracted with the medical center for these services. The hospital does assume full responsibility for payment and reimbursement of all costs related to the operation of the Center, thereby subsidizing approximately 37% of the total cost of providing this benefit to employees.

The Child Care Center is open from 5:45 a.m. to 12 midnight, seven days per week. Care is provided for children from one month to five years of age on a constant basis, and for children six to nine years of age when needed during the evening, on weekends, during school holidays, and in the summer months. The Center has 120 spaces available, and serves 210 children (185 families). Work schedules for medical center employees are extremely flexible, making enrollment and attendance fluxuate considerably. The

children are grouped by age and developmental levels into an infant group (one to ten months of age), a pretoddler group (eleven to eighteen months), a toddler group (nineteen to twenty four months), and a young two's class (twenty five to thirty months). In addition, there are four pre-school groups (for children two years six months to five years of age) separated by age and readiness levels. Each group of children has its own room and teacher. The Center has a staff of twenty full-time, ten part-time and four supplemental employees. Management of the Center is the responsibility of the two directors, who constitute the independent corporation contracted to supervise the operation of the Center and provide the staff.

The author is one of the Center directors, President of the corporation, and in charge of the administrative areas of the operation of the Child Care Center and of the corporation. Independent responsibilities include budgeting, public relations, enrolling children, scheduling children, record keeping, and supervising corporate financial matters. Joint responsibilities with the other director include staff selection, training, supervision, and evaluation; program planning, development, supervision and evaluation; contact with the parent committee which is the policy making body for the child care center; publication of a monthly newsletter and other communication about the center; and supervision of maintenance, purchasing, parent billing, and fundraising. Overall direction and operation

of the program rest with the two directors, as does the development and/or implementation of services to children, parents and staff.

Chapter 2

STUDY OF THE PROBLEM

Problem Statement

No effective system was operational at the Child Care Center to identify and assess children enrolled at the Center who might be potentially at-risk due to developmental delays, learning difficulties or behavior problems, and to further validate this assessment and provide evaluation of the needs of children so identified. In order to serve the children and parents using the Center in this important area of early identification, periodic developmental assessments of each child were necessary and a means of identifying at-risk children was essential. The process could not be limited only to the documentation of concerns, but needed to also include a means of validating those concerns and providing parents and staff with resources and assistance in meeting the special needs of the individual child. The Child Care Center had no objective, systematic means of identifying at-risk children. If developmental delays, learning difficulties or behavioral problems were suspected, the concerns were informally addressed without formalized access to resources to validate the concerns or to provide assistance to staff, parents, and children.

Documentation

The identification of children with special needs has been a focus of concern at the Child Care Center. The use of some type of assessment or evaluation procedure for children is important for many reasons, but in terms of identification of at-risk children, it is the vital first step in recognizing a child with special needs. In the early months of 1988, efforts were made to make available to child care staff an evaluation tool for use with the children in each group - infants, toddlers, and pre-schoolers. The Southeastern Day Care Project Rating Scale for Children in Day Care (1984) was selected. This instrument was chosen because of its versatility and its ease of administration. The varied patterns of children's attendance at the Center, due to parents' flexible hospital schedules, requires that a format for children's evaluations be concise, brief, and easy to use. The Southeastern Day Care Project Rating Scale met these criteria and provided assessments for children one month through five years of age.

Unfortunately, at the time of proposal documentation efforts, evaluations were not being done for a significant number of children in each age group, nor were the assessments being completed according to the guidelines for frequency suggested by the instrument's authors. A review conducted in January 1989 revealed the following information:

Table 1.

Number and Frequency of Evaluations Completed for Each Age Group

Age of children in months	Number of children in group	Number of evaluations completed	Number of evaluations completed within the recommended interval for assessment
0-12	21	5	5
13-18	23	6	6
19-30	31	11	4
31-48	33	16	15
49-60	45	26	13

Averaging the totals from the above table revealed that evaluations had been completed on 41.8% of the children. Significantly, only 28% of the children had been evaluated as often as is recommended in the guidelines for use of the rating scale. If assessments were not carried out and if children were not evaluated at appropriate intervals, it follows that it would be extremely difficult to identify those children who might be at-risk.

In February of 1989, a survey (Appendix A: 38) was distributed to sixteen teachers at the Center to determine to what extent the teachers were concerned about any of the children in regard to developmental delays, behavioral problems, or special needs. Nine of the teachers responded that they did have children in their groups about whom they were concerned. A total of ten children were identified whom the teachers felt would benefit from further assessment. In a follow-up conversation with each teacher

who had identified a child (or children) as a concern, the question was raised as to whether the teacher's concern was based on information obtained from using the Southeastern Day Care Project Rating Scale. Eight out of the nine teachers questioned responded that the concerns were not based on the use of the evaluation instrument.

Finally, a review of the Center's current informal system for identification of at-risk children as documented by parent conference records and physician referrals, revealed that in the course of the past five years a total of eight children had been so identified. Of those children, four had later been diagnosed by physicians as having medical problems, two later began counselling for emotional problems, and two were later enrolled in programs to address developmental delays. Only three of the eight children were identified since use of the rating scale began at the Center, and in only one case was the evaluation instrument useful in focusing attention on a developmental delay. If the majority of the above mentioned eight children were identified simply through an informal system of "sensing" a problem, or from a vague feeling the "something was wrong," the question arose as to whether other children with special needs or potentially serious delays were being overlooked without an effective systematic means of evaluation and identification.

Analysis

In order to identify and assess developmentally at-risk children, or those with special needs, it was necessary to have an effective means of evaluating the developmental levels and skills of all the children attending the Child Care Center. The assessment rating scale in use at the beginning of the practicum project was not effectively identifying children with problems. Initial analysis indicated that this was due inpart to the failure of staff to use the rating scale at the recommended frequency. A survey of 16 teachers completed at the end of February 1989 (Appendix B: 40) revealed that 14 out of 16 understood and felt comfortable administering the rating scale. Twelve out of sixteen felt that the scale evaluated important developmental areas, and 15 out of 16 were confident that the evaluation would help identify an at-risk child. In spite of this, however, only five of the teachers evaluated children as often as recommended, and only eight felt they had the time necessary to evaluate children in their group. This would indicate that the staff were not able to make use of the evaluation instrument in the time available to them. Either a different assessment tool needed to be found, or more time needed to be allotted on a regular basis to evaluation activity.

Beyond the problems with the assessment instrument, was the lack of a comprehensive plan to follow-up on concerns identified by teachers' assessments and observations. At

the beginning of the practicum project, teachers had no means of validating their concerns. There was no procedure established for communicating concerns to parents, or for drawing upon community resources for further evaluation, assessment and assistance. Although the Child Care Center is part of a hospital setting, there was no commitment of hospital resources for developmental evaluations of the children enrolled at the Center, and no assistance provided in assessing those children who might be developmentally, emotionally, or behaviorally at-risk.

Theoretical Support

A review of the literature showed that the identification of children at-risk because of developmental delays, learning difficulties, or behavior problems is an important concern. Peggy Sheridan from Connecticut College pointed out at a recent NAEYC Conference in Anaheim, California (November 1988) that contemporary reality in the United States is that, per 10,000 births, the incidence of developmental disabilities is approximately ten per cent. She also stated that there is a growing pool of handicapped children developing due to an increase in low birth weight infants, in infants who are surviving in spite of severe illness and trauma at birth, and in children impacted by AIDS and other contagious illnesses (Sheridan, 1989). In Washington State alone, out of the 188,178 children under five years of age whose mothers were employed outside the home in 1988, approximately 6,500 are likely to have a

developmental delay - defined as a limitation in motor, learning, self help, speech, sensory, or social/behavioral skills (University of Washington Child Development and Mental Retardation Center, 1988). In recent years services for children with identified handicaps and special needs have increased significantly. Nonetheless, a report by the Rochester School of Medicine and Dentistry for the New York Education Department (1982, p.2) states that

> Despite the increase in the number of services, many young handicapped children remain unidentified and subsequently unserved.

The tragedy of allowing these children to go unrecognized is compounded by the fact that children who begin with a deficit are much less well equipped to compensate for any further deficits produced by their environment.

Early identification is the vital first step in helping at-risk children. Such identification must

> pinpoint the child with 'special needs' so that we can speedily intervene to begin the process of more effective developmental learning or more or less specific remediation (Kansas University, 1982, p.59).

Children who benefit from this type of identification and intervention are those who are developmentally delayed, medically or biologically at-risk, and environmentally at-risk (Jordan and Erickson, 1987). In addition, early assessment of those abilities associated with later school success can focus on two dimensions related to risk status - academic aptitude and behavioral adaptability to classroom situations (Abramson, 1983), and offer the potential of

intervention to aid children in being more successful in later school experiences.

The benefits of early identification and intervention have been documented. The above-mentioned study by the Rochester School of Medicine and Dentistry (1982) pointed out studies by Clunier and Ross (1974) involving Down's syndrome infants, by Adelson and Fraiberg (1975) with blind infants, and by Horton (1976) with hearing impaired children under three years of age. All of these research studies revealed that greater gains were made in a shorter period of time by children receiving early intervention, when compared to similar children not receiving any intervention before three years of age. In addition, studies by Lazar and Darlington (1979), Schweinhart and Weikart (1980), and by Karnes, Schwedel, Lewis, Ratts, and Esry (1981) documented the benefits of early intervention in later years because the children served were more likely to be educated in regular settings in elementary and secondary schools. Finally, the research of Garland, Swanson, Stone, and Woodruff (1981) showed that the cost of education for children enrolled in intervention programs prior to two years of age was less than half the cost for children who did not receive services until school age (Rochester University, 1982).

The benefits of early intervention are being increasingly recognized. State and local communities, institutions of higher education, and groups and individuals

serving children are becoming increasingly involved in assessment and remediation services for children. More than twenty five states now require developmental screening for children three to six years of age, and public school involvement in early childhood education is bringing with it responsibilities to identify children at-risk for learning problems (Meisels, 1987). Teachers of young children are being recognized as the first individuals, after parents, most often responsible for collecting information related to the identification of children at-risk. This is a serious responsibility for early childhood programs and professionals - initially in the assessment of children to identify developmental delays and at-risk factors, and later in the referral to or provision of intervention services for those children.

Chapter 3

GOALS AND OBJECTIVES

The projected goals for this practicum included the plan that, after a period of three months, there would be an effective means of assessment and identification of at-risk children operational at the Child Care Center. This would include an assessment tool which would be used to evaluate 90 percent of the children attending the program, and used within the time specified for frequency of administration in at least 80 percent of the instances. Attainment of this objective was measured by recording the number of evaluations completed for children enrolled at the Center during the implementation period. However, it was not possible to record the frequency of evaluations because the evaluation instrument selected recommended that evaluations be administered at intervals longer than three months. The question of frequency was addressed in the follow-up staff questionnare. This procedure permitted a comparison with data gathered in documenting the need for an improved method of assessment. The targeted increase in the number and frequency of children's evaluations was projected as a 48.2% improvement in the number of children assessed, and a 52% improvement in the frequency of assessment.

In addition, a projected goal for the project was a program in place which would, in the event of a teacher's concern regarding the possibility of a child with special needs, provide the next steps in validating and acting upon that concern. This portion of the practicum project was to be judged effective upon approval of the guidelines and the resource and referral options by the Medical Center's Child Care Committee and a selected group of professional advisors from the Medical Center. This approval provided the necessary assurance that the plan for validating concerns about a potentially at-risk child and providing options for meeting the child's needs, would be operational, effective, and legally and medically sound. This means of measuring the outcome of this portion of the project was chosen because it would demonstrate validity even in the absence of any child identified during the implementation period as being potentially at-risk.

A final project goal was that at the end of the implementation period, 15 out of the 16 teachers at the center would feel that the method chosen for assessment of children and the follow-up procedures for validation adequately met the needs for a tool providing 1) sufficient teacher availability and time for administration, 2) a focus on the important areas of child development, 3) a means of identifying at-risk children, 4) and a plan for future assessment and intervention. Teacher response was measured by a follow-up staff questionnaire. It was planned that the

the results of this survey, when compared to those of the earlier questionnaire used in the documentation phase of the project, would show a small increase (3 teachers) in the number who felt the instrument evaluated important areas of child development, a moderate increase (7 teachers) in the number who felt there was adequate time to evaluate children, and a large increase (10 teachers) in the number who perceived themselves as being able to evaluate children in their group as often as recommended.

Chapter 4

SOLUTION STRATEGIES

Existing Programs and Models

The problem of identifying and providing services to those children at-risk, in the words of Lorraine Dreiblatt, M. Ed., for "not being successful or not progressing in development" (October, 1988) because of developmental delays, learning difficulties, or behavior problems, is gaining increasing attention. Pilot programs are being developed through children's centers, public schools, community health agencies, and private businesses. The initial step in all of these efforts is the identification process. There is general agreement with Dr. Meisels that children who need special services can be effectively identified by developmental screening and assessment (1987). Many assessment tools are available, and an early childhood program faces the challenge of choosing a valid and reliable instrument that is appropriate for the individual child and which can be administered by child care staff in the time available within the program.

Many experts suggest that assessment can focus on areas outside of prepared evaluation tools and instruments. Alternative assessment techniques mentioned by David Majsterk (1983) include Brinker and Lewis' focus on how a

child uses co-occurrences - responses to stimuli in the environment - to gain mastery over the environment. Majsterk's list also includes Jen's and Johnson's consideration of affective development as another measure of a child's cognitive level. Joyce Dumtschin (1988) focuses on assessing cognitive development through language development. Piaget's focus on the development of intelligence as aided by the development of play and imitation, provides another avenue of evaluation. Child Find programs use a frequency sampling of certain tasks that offer predictions for school performance.

The list of approaches to and options for screening and assessment is lengthy and varied, but the identification process is only the first step in meeting the needs of at-risk children. Identification is the first phase in the process, to be followed by more specific observation, evaluation, and diagnostic testing. These follow-up procedures validate the results of screenings and assessments. Given all of the factors involved in assessment, there does not exist at this time a test comprehensive enough to cover the full range of abilities nor precise enough to make the fine distinctions that are necessary (Kansas University, 1982). Therefore, follow-up procedures are essential in order to validate initial assessments and offer intervention strategies.

There are programs in operation which provide a comprehensive approach to the identification of at-risk

children. In the New York State Regulations of the Commissioner of Education, a program is outlined for the identification of handicapping conditions (Rochester University, 1982). The process begins with an instrument to provide information on risk factors such as prematurity, low birth weight, alcoholism, disorders during labor and delivery, poverty, accidents, and family history. The next step is a series of developmental screenings including the Rapid Developmental Screening Check List, the Denver Developmental Screening Test, and the Boyd Developmental Progress Scales. For pre-school children, parents also complete a questionnaire called the Preschool Screening System. These evaluations are followed by complete auditory and visual screenings done by health professionals.

Another comprehensive plan of assessment is in place as part of the Head State program. In Head State programs, screening is viewed as a detective procedure through which children are identified who may be in need of further evaluation and special services (Wolfe, 1982). The teacher is responsible for collecting information on a child through observation, information from parents, screening results, or educational assessment results. This process includes information provided by parents regarding pregnancy, birth, and infant-toddler developmental milestones. A health screening - including growth assessment, vision and hearing testing, and speech evaluation - is another important part of the assessment. Developmental and educational screenings

are included, and focus on language, cognitive, motor, and social-emotional development.

In the process of collecting this information, a Head State teacher may become aware of at-risk signs - behavior or information indicating that a child may need further evaluation. A common criteria used as a basis for referral is the existence of a 25% or more delay in one or more developmental or educational areas (Wolfe, 1982). Those children identified as at-risk are referred to a professional team trained in assessing handicapping conditions. The multidisciplinary team reviews the need for a referral, discusses the concerns with the parents and obtains permission for a diagnostic evaluation, chooses the appropriate diagnostician, makes a referral, contacts the diagnostician, attends the evaluation, and obtains and shares the diagnostic results. Within this very comprehensive approach to the early identification of children with special needs, Head Start programs are in a position to help prevent and/or correct some handicapping conditions (Wolfe, 1982).

Another important program for early identification of children at-risk for developmental delays is a collaborative program of the Pierce County Community Action Agency, the Metropolitan Developmental Council, and the Tacoma/Pierce County Health Department (Cates and Nelson, 1988). This program, called Child Reach, provides screening clinics throughout Pierce County, and is designed to access

economically disadvantaged children who might benefit from early identification and referral to services offered in the community. Parents who have questions or concerns about a child's vision, hearing, cognitive development, social interaction, physical growth, or any other areas, are able to take advantage of this free screening service. Early childhood educators are able to refer parents to this important resource.

The Child Reach screening process includes a parent questionnaire detailing parent observations and perceptions regarding their child's growth and development, as well as any concerns they might have about their child. Two sets of screening tools are used as part of the assessment. The first is the Infant-Toddler Screening (ITS), which includes the Early Language Milestone Scale (ELM), the Bricker Developmental Screening, and the Chandler Assessment for Motor Development. The second tool is the CHILDFIND screening for children three to five years of age, which includes vision and hearing testing, language and cognitive development evaluation, motor assessment, and the Pre-school Behavior Inventory. A team of volunteers, including a physical therapist and a speech pathologist, conduct the screenings, which provide a needed service to the children of Pierce County. From June through August of 1987, the CHILDREACH program served 175 children. Twelve percent of those children qualified for school district or Department of Developmental Disabilities programs. Over 45% of the

children required other professional referrals related to identified special needs (Cates and Nelson, 1988).

Renton Vocational Technical Institute and the Seattle-King County Department of Public Health have also developed a set of guidelines for early childhood programs to assist child care providers in responding to children who are a concern (Yamaguchi and Renton, 1988). The first step in this process is the observation and documentation made by the teacher and other child care staff of the behavior and/or situations that have raised questions or concerns about a particular child. The guidelines then suggest that the teacher and center director confer about the situation and decide upon a plan of action, which would include a meeting with parents to discuss the problem. At this point, parents and center staff may agree upon a course of action involving only the home and the child care center. Other options could include addressing the possibility of physical causes and a recommendation for appropriate health screenings. The guidelines provide a framework for requesting parental permission for an independent qualified observer (health department nurse, child development specialist, or other professional) to aid the parents and teacher in pinpointing the causes of the problems and in meeting the needs of the child. Community resources that provide observation and identification services are listed, as well as screening and assessment resources and those offering treatment and intervention assistance. This

approach offers a comprehensive and concrete means of addressing the needs and concerns of children, parents, and teachers.

Solution Strategies

In order to achieve the objective of having an effective system in operation at the Child Care Center for identifying children potentially at-risk, it was necessary to focus on four separate components of a proposed program.

First, it was important that a form be developed, to be included with registration materials, that would give parents the opportunity to share information with Center staff regarding pregnancy, a child's birth history, family background, medical history, and any other factors important to the child's growth, development, and well-being. All of the programs mentioned earlier had as a component a means of soliciting information from parents regarding the health, development, and health history of their child. Assistance from the continuing education department of the Medical Center and from the Child Life specialist were available for the development of this information tool. In addition, examples of similar forms collected from other programs served as models. The cost of including an additional form in registration material was minimal and did not pose a problem.

Another important task was that of finding a sensitive, valid, and reliable screening instrument. The suggestions offered in the Training Guide for Development of the

Individual Service Plan in Head Start (Wolfe, 1982) were particularly applicable to this portion of the project. It was necessary that the instrument chosen be appropriate for the children screened and the program in which they were participating. Consideration needed to be given to the developmental areas evaluated by the instrument, how the screening was to be administered, who could administer the assessments and the amount of training required, the time needed for the screenings, and to the cost of implementing the assessment process. Staff input was essential in choosing the method and format of evaluation, and in determining how and when screening would fit into Center routines. Training staff in the administration of the assessment tool was a consideration as well as the cost of the screening instrument.

The third important task was the development of guidelines and procedures to be followed when a child is identified by Center staff as a concern. The program of Renton Vocational Technical Institute and the Seattle-King County Department of Public Health suggested procedures for conferencing with the program director, documenting concerns, conferring with parents, and obtaining parental permission for outside observers or for release of information to other professionals (Yamaguchi and Gross, 1988). It seemed that a plan of action including these components would be a valuable resource for the staff of the Child Care Center. Assistance from the hospital legal staff

was available in determining documentation procedures and in drafting parental permission forms.

The final component of this project involved gathering information on the screening and assessment resources in the local community - including those available through the Medical Center - and formalizing a means of accessing these services. It was hoped that the resources available would include qualified individuals who would be able to visit the Center for observations. Hospital staff or hospital programs might be available to Center staff and parents. Additional services could be obtained from public and private programs in the community. The Medical Center's Child Care Committee would provide the necessary review and approval of outside individuals and agencies, including review of any costs connected with the services.

Implementation

The first goal of the practicum project was the establishment of an effective means of assessment and identification of at-risk children attending the Child Care Center. The attainment of this goal involved two phases of activity which proceeded simultaneously during the implementation period. One task consisted of a revision of registration forms to include solicitation of important health and developmental information from parents - information which would be a valiable resource to childcare staff. The second task involved review, selection, and

implementation of a screening instrument to be used at the Child Care Center.

In revising registration forms, the first step involved gathering sample parent information forms from other childcare centers and agencies. The author collected forms that requested information on prenatal and birth history, family and medical history, and other significant developmental information. Childcare centers in the area, as well as other hospital childcare programs, were contacted. Individuals from the Medical Center's continuing education department and from the nursing education center were helpful in providing information and resources. Head Start materials were extremely helpful. With the information collected, the Center's co-directors worked together to develop an appropriate form, which was subsequently submitted to the Child Care Committee (the committee of parents and hospital administrators which determine policy and direction for the Child Care Center) for review and approval. The committee considered "right of privacy" and "infectious disease" concerns and recommended review by the Medical Center's risk management director. This review and approval were obtained, and some committee members completed the forms (Appendix C: 42) to more fully review their feasibility. The final step in this process was the discussion of the forms with Center staff and the introduction of the forms to all of the parents through the Center's newsletter.

At the same time, work was proceeding on the review and selection of a screening instrument to be used to evaluate children at the Center. The author gathered different evaluation instruments that met the criteria of validity, reliability, comprehensiveness, ease of administration, availability of training, and affordability. The instruments considered were the Denver Developmental Screening Test, the Minneapolis Preschool Screening Instrument, the Early Screening Inventory, the McCarthy Screening Test, the Learning Accomplishment Profile and Early Learning Accomplishment Profile, the Lexington Developmental Scale, the Portage Guide to Early Education, and the Southeastern Day Care Project Rating Scale which was then in use at the Center. Information on these evaluation instruments was made available to the staff, and the site coordinators facilitated informal discussions of the goals of the project and the screening options. A staff meeting was held at each building for the purpose of formal discussions of the evaluation instruments. The site coordinators recorded staff comments and recommendations. Staff members were interested in one instrument which would serve all ages at the Center, rather than several different screening tools for different age groups. They preferred concise evaluations which could be easily administered. They expressed approval of a comprehensive screening that would include sufficient focus on social/personal skills. In addition, they looked at the comprehensiveness of

instructions for administration of the screening, resources and materials provided or available, and the presence of guidelines as to what constituted "mastery" of a skill by a child being evaluated. The evaluation instrument selected by the staff was the Lexington Developmental Scale.

The next step in the process of providing an effective screening and assessment tool was the training necessary to insure that Center staff understood the instrument, were comfortable administering the screening, and had sufficient time for the evaluation process. The author obtained copies of the guide to administration of the Lexington Developmental Scale, organized this material into a workshop format, and conducted a training session with childcare staff at each building. These presentations included guidelines and procedures, resource materials, sample evaluation, and staff participation. In addition, discussion of ways in which to include administration of the assessments in each teacher's daily schedule was an important focus of the inservice meetings.

All was then in place for the actual implementation and use of the screening instrument. This did not proceed quite as smoothly as originally planned. Evaluating the children during the Summer months caused special problems. Enrollment at the Center fluxuated considerably due to vacations and children leaving the program. Vacations for staff members limited the amount of time available to each teacher for completion of the assessments. As a result, the

implementation phase of the project was extended six weeks - into early Fall. This enabled the staff to have sufficient time to administer the assessment.

As the staff began to use the Developmental Scale, questions were answered, problems worked through, and helpful materials gathered together. It was collectively felt that this phase of the project would be viewed as the "trial period" out of which would come the knowledge, skills, and expertise for the agreed upon schedule of yearly assessments to be done in October and April for toddlers and pre-schoolers, and in October, January and April for infants and pre-toddlers. After the screenings were completed, a follow-up survey of the number of children assessed and the satisfaction of the childcare staff with the screening instrument was conducted.

The second goal of the practicum project was a program in place which would, in the event of a teacher's concern regarding the possibility of a child with special needs, provide the next steps in validating and acting upon that concern as well as a resource network of experts from the hospital and the community to provide assistance in validating concerns and in meeting the needs of the children. Initially, information was gathered from other childcare centers, hospital centers, and community organizations in regard to procedures for responding to concerns about children. These were combined, revised, expanded, and adapted by the author to form a set of

guidelines for step by step response in the event that a staff member had a concern about a child. The guidelines included documentation strategies, recommendations for parent conferences, and aids for staff in focusing and detailing their concerns. Also included were forms for parental permission for an independent observer and for release of information. Assistance in developing these forms was provided by the hospital's medical records department through access to their Standardized Consent Manual. In addition, the forms were reviewed by the risk management director.

The next task was the compilation of a list of resources for assistance with validation of staff concerns regarding children who might be at-risk - including qualified observers to visit the classroom, resources within the Medical Center, and community screening and assessment services. Contact with the Hospital's Vice-President of Personnel Services was at first discouraging. Concerns were voiced about potential liability in providing these types of services and resources; however, the author was able to obtain the names of three department heads who might be able to offer assistance if the Center and/or parents were to pay for any costs involved - provided that the entire plan, including staff guidelines, were approved by the risk management department of the Medical Center. The author spoke with the hospital personnel and was able to arrange for the services of a physical therapist and a speech

pathologist as independent observers who would visit the Child Care Center if needed to observe a child and evaluate the need for further assessment. In addition, the author compiled a list of other resources within the Medical Center and the community that provide screening, assessment, and treatment services.

The above mentioned guidelines for staff and resources for assistance were compiled into a manual entitled, If A Child Is A Concern: A Guide For Child Care Center Staff (Appendix D: 46). The manual was submitted to the hospital's director of risk management and received his approval. It was also submitted to the Child Care Committee for review. The Committee expressed support for the plans and procedures, and felt that the revised registration forms, newly adopted screening instrument, and the guidelines and resources outlined in the staff manual constituted a plan in place that would identify and provide follow-up services to children who might be at-risk.

The final step in the implementation process was the review and discussion of the entire project with the Center staff - including summarization of recent activities, solicitation of suggestions and recommendations, and review of the staff manual. The process also involved completion of a follow-up staff survey addressing the effectiveness of the new evaluation instrument and of the procedures outlined in the staff manual (Appendix E: 63).

Chapter 5

RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

As a result of this practicum project, there is now a means of assessment and identification of at-risk children operational at the Child Care Center. This includes a new evaluation instrument for assessing the children enrolled at the Center. During the implementation period, out of the 65 possible evaluations to be completed, 60 children were evaluated. This is an improvement of 50% over the use of the former instrument in the number of children assessed, and the attainment of one of the goals of the project. It was not possible to address the frequency of evaluations during the short implementation period due to the fact that the evaluation instrument chosen recommends that children be assessed at longer intervals - every three months for infants and pre-toddlers and twice a year for toddlers and pre-school children. The goal of improved frequency of evaluations (by 52%) will need to be monitored as the year progresses.

Another result of this effort is the program which is now in place at the Center, which will provide the steps to be followed to validate and address a teacher's concern th. a child might be at-risk for developmental delays, learning difficulties, or behavioral problems. The Center's Child

Care Committee and other advisors from the hospital have approved the guidelines and the resource and referral options, and have concluded that the plan for validating staff concerns and for providing options to meet a child's needs would be effective. This was a project goal to determine success even in the absence of a child being identified during the implementation period as being potentially at-risk. The cost of services provided by the hospital's speech pathologist and physical therapist - as observers at the Child Care Center - will not be prohibitive and will be part of the Center's budget.

Finally, as demonstrated in the results of the follow-up staff questionnaire, all of the 16 teachers at the Center felt that the method chosen for assessment and the follow-up procedures for addressing teacher's concerns constituted a means of identifying at-risk children and a plan for future assessment and intervention. All of the teachers also felt that the screening instrument and resources focused on important areas of child development. These results, when compared to those of the survey used in the documentation phase of the project, show an increase of 4 teachers who feel the evaluation instrument focuses on important areas of child development, and an increase of 10 teachers who believe they will be able to evaluate the children in their group as often as recommended. These increases met two of the staff survey goals projected for the project. However, a third goal addressing teachers' perceptions of having the

necessary time to evaluate the children in their groups was only partially met. Only 11 of the 16 teachers felt that they would have sufficient time to do the evaluations, and concerns were expressed regarding the tasks that are already regularly required of staff. When follow-up discussions were conducted, a plan was formulated to schedule additional staff during hours when the teachers would be conducting evaluation activities requiring work with children on a one-to-one basis. The additional staff hours would not significantly impact the budget due to the fact that the teachers who felt a time constraint would be able to share the additional staff during the two evaluation periods scheduled per year.

This project has produced important changes at the Child Care Center. The staff now have available important developmental and health information provided by parents. They have participated in the selection of an assessment tool and feel comfortable with their choice and with their ability to assess the children in their group and to respond if they have a concern about a child who might be at-risk. This has significant implications. If one additional at-risk child is identified because of these changes, it will be all that is needed to declare the project an overwhelming success. In addition, the Center now has a working network of resources to draw upon for assistance in evaluating and meeting the needs of children. This will provide much needed support for the teachers since, unfortunately,

sometimes they are not viewed as the professionals they truly are. Finally, the Center now has a step-by-step guide to assist staff in formulating, documenting, and addressing a concern about a child. Members of the Child Care Committee felt this was one of the important values of the staff manual - that concerns would not be addressed haphazardly or pushed into the background. In fact, in the final week of the implementation period, the manual served as a guide for staff in conducting two parent conferences dealing with several minor concerns about the children being discussed.

The changes brought about during this practicum project will continue to be an ongoing asset to the Child Care Center. The new parent information forms are a permanent part of the Center's registration packet. The new evaluation instrument will be an important tool for the Center staff. The manual and resource individuals and agencies are a valuable addition to the Center's reference materials. In addition, the author plans to share the basic elements of this project with other child care professionals through a presentation at the annual winter conference hosted by the local NAEYC affiliate.

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Appendix A: Survey of Teacher's Concerns

Child Care Center

---------------.

Do you have any children in your group that you are concerned about in terms of developmental delays, problems in the group, etc. - children that from your observations and evaluations you feel would benefit from further evaluation, perhaps by a physician or other health or education professional:

Circle one: YES NO

If yes, please write the names of the children below:

We need this data for setting up a resource-evaluation service. Please return to Kathie, even if you have circled NO. Thanks.
(Put in office or office folder. Don't leave out, since this is confidential information.)

Appendix B: Survey Of Effectiveness of Present Rating Scale

In using the Rating Scale for Children in Day Care, have you found that (check all that apply).....

1._____You evaluate children in your group as often as recommended in the instructions for use of the scale.

2._____You understand how to use the rating scale.

3._____You feel comfortable using the rating scale to evaluate the children in your group. (For example, you are able to determine whether or not the children are exhibiting those behaviors listed.

4._____You have time to evaluate the children in your group using the rating scale.

5._____The rating scale evaluates those areas of development that you feel are important for children in your group.

6._____The rating scale helps you focus on areas of development that may need extra observation or attention. (For example, the rating scale would help you identify a developmentally at-risk child.)

Please take a few moments to complete this brief summary. No name is necessary. This information is important in reviewing the effectiveness of our means of assessing the children here at the Center. Please be accurate and frank in your responses. Thank you for your time and input.

Appendix C: Registration and Health History Information

CHILD CARE CENTER

REGISTRATION INFORMATION

Please share with the Child Care Center staff the information that applies to your child. This will help us to better understand your child and to give him/her the best possible care.

Social

Contact your child has had with adults and other children:_____

_____

Previous childcare experience:_____

Favorite toys and play activities:_____

Emotional

Does your child have any fears (loud noises, darkness, animals, etc.)?_____

_____

Is he/she very dependent on anyone?_____

Have you noticed any particular behaviors that indicate stress in your child (twirling hair, sucking thumb, biting, etc.)?_____

Discipline

What kind of discipline works best at home? _____

Food

Is your child drinking breast milk_____, formula_____, 2%milk_____, whole milk_____, other_____?

Does your child eat table foods?_____ Which foods?_____

Does your child take a bottle? Yes_____ No_____

drink from a cup? Yes_____ No_____

feed him/herself? Yes_____ No_____

use a spoon? Yes_____ No_____

Please note your child's normal schedule for eating (and taking a bottle):

_____

_____

_____

Does your child have any food dislikes or food allergies?_____ If yes, please list.

_____

(Please indicate which are dislikes and which are allergies.)

Feeding problems (reflex, etc.)?_____

Naps

Does your child have any special needs at nap time?_____

Has your child been taking an afternoon nap? _____ If yes, how long does he/she sleep?_____

Does your child use a pacifier?_____ suck his/her thumb?_____

Please note your child's normal schedule for sleeping (day and night):

_____

_____

Toileting

Is your child fully responsible for his/her own toileting?_____

Is your child in the process of being toilet trained?_____

What expressions does your child use to make his/her toileting needs known?_____

_____

Have you had any difficulties or problems with your child's toileting or toilet training?_____

To what degree can your child dress him/herself?_____

CHILD CARE CENTER
HEALTH HISTORY

CHILD'S NAME _____ SEX_____ BIRTHDATE_____
CHILD'S PHYSICIAN_____ PHONE_____
CHILD'S DENTIST _____ PHONE_____

DATE OF LAST PHYSICAL EXAM _____

PREGNANCY/BIRTH HISTORY

Did Mother have any health problems during pregnancy or during delivery? _____
_____
Was Mother using medications, alcohol, or smoking during pregnancy? _____
Was child born more than 3 weeks early or late? _____
Child's birth weight _____
Did child have any problems at birth? _____

HOSPITALIZATIONS AND ILLNESSES

Has child ever been hospitalized, had surgery, or had a serious illness ? If yes, please explain.
_____
Has child ever had a serious accident (broken bones, head injuries, suffered burns, ingested a poisonous substance)? If yes, please explain.
_____

ALLERGIES

Does child have any allergies? _____ If yes, please complete information below:

Allergen	Reaction	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILD HEALTH PROBLEMS (Check any your child has or has had and give date(s).

Asthma_____
Eczema_____
Epilepsy_____
Diabetes_____
Failure to thrive_____
Heart Murmur_____
Scarlet Fever_____
Hepatitis_____
Anemia_____
Tuberculosis_____
Pneumonia_____
AIDS_____
Measles_____
Rubella_____
Mumps_____
Chickenpox_____
Polio_____
Lead poisoning_____
Whooping Cough_____
Rheumatic Fever_____
Sickle Cell Disease_____
Bleeding tendencies_____
Heart Disease_____
Meningitis_____

FAMILY HEALTH INFORMATION

Are Mother and Father in good health? _____ If no, please explain.
_____
Are brothers/sisters in good health? _____ If no, please explain.
_____

CHILD HEALTH CONCERNS

Does your child have ear problems such as hearing_____, earaches/infections_____, tubes_____, other_____? If yes, please explain.

Does your child have eye or vision problems?_____ If yes, please explain.

Does your child wear glasses and/or an eye patch? _____
Do you have difficulty understanding your child's speech?_____ Do others?_____
Has your child ever been tested for or received speech therapy?_____ If yes, please explain.

Does your child have dental problems? _____ If yes, please explain.

Has your child ever had a convulsion or seizure? _____ If yes, please explain.

Does your child have frequent sore/strep throat _____, cough _____, urinary infections or trouble urinating _____, stomach pain, vomiting or diarrhea _____, constipation _____. If yes, please explain.

Does your child have any health problems that interfere with daily activities? _____ If yes, please explain.

Does your child take any medications? _____ If yes, please list.

How do you take your child's temperature? _____

Do you have any concerns about your child's health or growth and development? _____ If yes, please explain.

Medical insurance for children enrolled at the Child Care Center is the responsibility of parent/guardian.

Thank you for taking the time to complete this health history form. The information provided will help us to better meet your child's needs and to provide the best care possible for him/her.

Appendix D: Manual For Child Care Center Staff

IF A CHILD IS A CONCERN: Identifying Children With Special Needs

A Guide For Child Care Center Staff

IF A CHILD IS A CONCERN: Identifying Children With Special Needs

INTRODUCTION

In your position as teacher/caregiver you may encounter a child who seems to have a more difficult time while at the Child Care Center than other children. Have you noticed a child who seems to need something special to help him/her along? In using the Center's assessment instrument, have you noted significant delays or a failure to progress developmentally? If you have a concern about a child in your care, the following information and materials are designed to help you respond to that concern, to assist you in documenting and analyzing relevant behavior, and to guide you in initiating a process to determine the needs of that child and the ways in which parents and caregivers can respond to those needs.

STEP I: Try to pinpoint the specifics that constitute your concern.

A. Review the child's growth and development as noted in the most recent data from the Center's assessment instrument. Readminister the instrument if necessary.
B. Review the "Key Problems" list included in this packet. On a separate sheet of paper note any of these characteristics that apply to this particular child. Ask yourself, "Is his/her behavior making things hard for him/her so that he/she is not progressing?"

STEP II: Documentation Strategies

A. Record the child's progress in detail on the Center's evaluation instrument.
B. Review the "Signs of High Risk" section of this packet. On a separate sheet of paper record the behavioral and developmental signs that you have noticed. (For each, note specific instances, dated if possible.)
C. Complete the "Questions To Ask Yourself" sheet in the packet. Make a copy first so you can complete it for a specific child.
D. Compile anecdotal records of those behaviors which are a concern. Include date, time of day, circumstances, participants, and all other important information in recording "what happened."
E. Chart the frequency, duration, or intensity of the behavior over a specific period of time - day, week, month, etc.

STEP III: Responding To A Concern

A. Set up a conference meeting with the site-coordinator and the director(s) to discuss the situation and your concerns. At this meeting try to determine what the Child Care Center and Center staff can do to address the problem. Obtain input from other staff who work with the child to help formulate an action plan.

B. If appropriate, the teacher and site-coordinator (perhaps directors) will set up a meeting with the child's parents to discuss the concerns and to solicit input and information from the parents. (This meeting would build on the frequent and on-going communication that is maintained with all parents.) Discuss recommendations and action plan at this meeting. Keep in mind that suggesting a physical exam by the family physician can be an important part of an action plan. At this time a means of regular communication should be agreed upon. After the meeting, the site-coordinator or director will prepare a written summary of the action plan and recommendations, noting the responsibilities of the Center and Center staff and the responsibilities of the parents. A copy will be given to the parents.

(If parents are unwilling to participate in the action plan or are unwilling to address the problem, a meeting should be scheduled with the directors and a time frame agreed upon for improvement of the situation.)

STEP IV: Further Response

A. If the action plan is successful and there is no longer a concern - rejoice and continue on-going communication!

B. If concerns continue, the directors will request parental permission for a qualified independent observer to assist parents and staff in evaluating the situation. (If parents refuse, a qualified observer could still visit the classroom, but would have to focus on the teacher's actions and the teacher's performance. For example, the observer could note that an excessive amount of the teacher's time was devoted to interactions with a particular child.) During this discussion with the parents, the directors will discuss the role of the independent observer and other outside resources available. In addition, parents will be asked for a written release of information so that what the Center staff have observed can be discussed with outside professionals. (Without this release, such conversations would violate the child's right of privacy.)

C. From the observations and input of the independent professional, or with the services provided by other outside resources, another plan might be designed. The teacher would meet with the parents to discuss the plan and obtain their approval and participation before implementation.

D. If staff and parents seek outside help, suggestions to the Center must be feasible for implementation within the Center's operation and philosophy. A written plan of action should be given to the directors to facilitate staff implementation. Written communication should be ongoing between parents and the Center. (Keep copies of all communication.) It is helpful to ask parents how they would like to receive this information and how often. In a particularly difficult situation, it may be advisable for parents and directors to review notes of meetings and sign them.

STEP V: Possible Consequences

A. If intervention is successful or improvement is observed - rejoice and continue on-going communication!

B. If the needs of the child cannot be met at the Child Care Center, or if concerns continue without improvement, it is time for the directors to recommend that the parents select another facility within an agreed upon time. The directors will try to assist with appropriate placement.

IF A CHILD IS A CONCERN

KEY PROBLEMS

A child who does not seem to learn. S/he lags behind others in basic skills and is not helped by the usual learning experiences.

A child who does not seem to make friends. S/he may avoid others or may do things which make others want to avoid her/him.

A child who talks or behaves like a much younger child.

A child who seems unhappy or tired most of the time.

A child who gets sick because of school or personal problems.

KEY PROBLEMS

This is a list of sixteen types of behavior which can help a teacher recognize children with special needs. Keep these behaviors in mind as you get to know your children throughout the year. Keeping observation notes or short anecdotal records can be very helpful in sorting out problems. Review this list keeping in mind the age and developmental level of the child.

1. Short attention span; inability to concentrate.
   Child is not able to pay attention long enough to finish an activity.

2. Restlessness or hyperactivity.
   Child moves around constantly, fidgets, does not seem to move with a purpose in mind.

3. Non-completion of tasks, carelessness, unorganized approach to activities.
   Child does not finish what is started or does not seem to know how to plan to accomplish a task.

4. Listening difficulties.
   Child has trouble following directions, turns away while others are talking, does not seem to be interested.

5. Avoiding participation with others or hurting others as the only means of play.
   ~~Child stays away~~ from other children, always plays alone, leaves the group when an activity is going on, bites, hits, or bullies.

6. Avoiding adults.
   Child stays away from adults, dislikes coming to adults for attention.

7. Repetitive behavior.
   Child does some unusual movement or repeats words over and over, cannot stop this activity himself.

8. Ritualistic or unusual behavior.
   Child has a fixed way of doing certain activities - in ways not usually seen in other children.

9. Excessive resistance to discipline or direction.
   Child does not accept any directions or training, destroys materials or toys deliberately.

10. Unusual language content (bizarre, strande, fearful).
    Child uses extremely odd language in talking with others or in stories.

11. Speech problems.
    Child's rate of speech is unusually fast or slow. Child has difficulty making clear speech sounds; stutters; has unusually loud,soft, high or low voice tone; or chooses not to talk at all.

12. Physical complaints.
    Child talks excessively of being sick or hurt, seems frequently tired and lacking energy.

KEY PROBLEMS, continued

13. Echoing another's speech.
    Child contiually repeats another person's words without intending the words to mean anything.

14. Lack of self-help skills.
    Child is unable to feed self, dress self, conduct toileting unaided, wash hands or brush teeth when he/she should be developmentally able to perform these tasks.

15. Self-aggressiveness or self-criticism.
    Child does things to hurt self or frequently makes negative statements about self.

16. Depression and extreme sensitivity.
    Child is very moody, unhappy, easily depressed and irritated.

SIGNS OF HIGH RISK—

BEHAVIORAL SIGNS

The meaning of all behavior is relative to the age and environmental situation of the child who manifests it. There are virtually no behaviors which always can be considered to be indicative of problems. What is a "problem" or maladaptive behavior at one age may be adaptive or even typical at another age. A behavior which one parent or teacher finds intolerable and therefore a "problem" may be highly valued behavior for another parent or teacher. However, there are some behaviors which, if they persist to school age, are likely to create problems for the child in a majority of academic and social settings in our culture as it exists at present. These behaviors warrant careful observation over a period of time; and in cases where they persist more than six months or are unusually severe, they should be evaluated further.

1. Problems in interacting with the environment (in alertness or receptiveness to environmental stimuli, in activity level, or in acting upon and responding to stimuli in the environment).
    a. The infant who does not turn to sound, does not look at bright or moving objects, does not "track" visual stimuli, or does not reach for an object near his grasp.
    b. The infant who overresponds to any external stimulus such as noise, touch, or light (startles easily, cries, covers ears or eyes).
    c. The infant or toddler who is a "good" baby, remaining silently where placed, never getting into things, and generally showing a lack of exploratory behavior.
    d. The overly active toddler or child who is constantly and inappropriately engaged in physical activity, showing no restraint or ability to respond cognitively to his environment.
    e. The child who continually destroys his environment - breaking toys, throwing things, tearing, cutting, burning, or otherwise inappropriately defacing property. (This type of destructiveness needs to be distinguished from normal amounts of breakage which may happen in the course of exploratory play.)
    f. The child who cannot attend to a stimulus or an activity for an age-appropriate period of time, but contantly "spins" from one thing to another without getting involved in anything.

2. Problems in interacting with other people (in responding with appropriate affect to other people, in initiating contact with other people, in communicati in assertiveness).
    a. The infant who, by about sixteen weeks, does not smile, gurgle, or otherwise show pleasure when approached or cuddled.
    b. The infant of ten months to one year who typically does not cry when mother leaves or has been out of the waking infant's sight for a period of time. (This applies in unfamiliar situations and surround
    c. The child who at approximately one year of age does not yet seem to differentiate between strange and familiar persons (shows no fear of strangers or no particular recognition of his mother).
    d. The infant who does not begin using verdal output to communicate and control in some manner by one year.

e. The child who does not begin to make a transition from physical relationship with others to verbal interactions by age four (who relates by hitting, pushing, pulling, biting).
f. The child who is excessively dependent upon parents and can spend no time alone (who whines, clings, or crys excessively upon separation).
g. The child who shows no interest in parents' or other persons' comings and goings, occupying himself completely in solitary pursuits.
h. The child who shows no interest, either positive or negative, in other children.
i. The child who uses temper outbursts or negativism to control others in excessive degrees or beyond the age of three.
j. The child who, at age four, cannot share or wait his turn.
k. The child of four who cannot involve himself in group activities or interactive games withother children (remaining oblivious, or standing on the sidelines and resisting attempts to involve him).

3. Problems within the self.

a. The infant or child who is totally engrossed in himself, engaging in self stimulating behaviors as a major activity.
b. The child who repeatedly harms himself physically (biting, pinching, banging head, etc.).
c. The child who generally appears sad, or the child who shows unusually flat affect (no appropriate signs of pleasure, sadness, fear, anger, etc.).
d. The child who lacks confidence in self (frequently saying "I can't, or otherwise criticizing self).
e. The unusually anxious or fearful child whose fears interfere with normal activity (excessively fearful of new situations, water, physical activity, etc.).

SIGNS OF HIGH RISK

DEVELOPMENTAL SIGNS

It is important to be aware of general developmental milestones for self-help (eating, sleeping, elimeinating, and other self-care behavior), motor, and language development. If a four to six month delay in any area is noted, the child should be observed carefully. If the lag continues to be apparent, even if some progress has occurred, the child's development should be evaluated further.

1. Problems in gross motor development (in using the large muscles of the body).
    a. The child who is unusually slow in walking (later than 18 months).
    b. The child who frequently stumbles, falls, or bumps into things
    c. The child who avoids motor activities such as riding tricycles, throwing, hopping, or perhaps even running.
    d. The child who cannot do age appropriate motor activities even though he tries.

2. Problems in fine motor or visual-motor development (in using small muscles, and in coordinating eyes and hands).
    a. The child over two years old who is always spilling his milk (accidentally), or dropping things. The child over three years old who has difficulty eating with a spoon and fork, or who cannot remove any of his own clothing.
    b. The child of four years who shows no interest in using crayons, pencils, scissors, etc.
    c. The child of four years who cannot use the materials listed in item b. or who cannot independently put together simple preschool puzzles or build with blocks.

3. Problems in visual perception, sequencing, and memory.
    a. The child over three years of age who continually tries to force puzzle pieces into the wrong spaces in a puzzle.
    b. The child over three years of age who cannot match identical objects by colors, shapes, sizes, or other simple similarities which are identified for him.
    c. The child over three years of age who repeatedly puts on his own or a doll's outer garments before undergarments or shoes before socks, even after repeated demonstrations of the correct sequence.
    d. The child who cannot remember the location of a toy or article of clothing even though it is always kept in a specific place. The child who frequently mistakes a sibling's or peer's clothing or other possessions for his own.

4. Problems in auditory perception, sequencing, and memory.
    a. The child who continually mispronounces words - incorrectly sequences the sounds (pasketti for spaghetti).
    b. The child who appears to hear but frequently says "huh?" or "what?" or looks blank when spoken to.
    c. The child over two years who cannot follow simple verbal instructions correctly, or who forgets simple directions enroute, such as "bring me the newspaper."

d. The child over two years of age who cannot correctly repeat a verbal comment or sentence immediately after it is given.
e. The child over three years of age who cannot remember any part of a story after it is read to him.

5. Problems in receptive language.

a. The child who has an adequate vocabularly for his age, but frequently responds to questions with inappropriate answers.
b. The child over three years of age who shows no interest in listening to stories.

6. Problems in expressive language.

a. The child of age three who does not talk.
b. The child with speech articulation problems - relative to age.
c. The child who remains "physical" in controlling his social environment beyond three years of age.
d. The child who has an adequate vocabulary but cannot put his feelings into words - cannot say that he likes or dislikes, is happy or sad, etc.

7. Problems in cognitive development.

a. The child of approximately three years of age who uses labels indiscriminately (calling all small animals "dog" because he has a dog) , or incorrectly (calling "boys" girls, etc.).
b. The child who is slow to develope basic concepts such as "up" and "down."
c. The child who, by thirty months of age cannot give his own name, or identify any of his body parts on request, or tell if he is a boy or girl.
d. The child who cannot solve even rudimentary problems others his age are able to solve.
e. The child of four or five who is not beginning to identify colors or to compare objects and identify "same" or "different."
f. The child of four or five who is not developing some rote knowledge of alphabet letters, numbers, stories, nursery rhymes, etc.

IF A CHILD IS A CONCERN

QUESTIONS TO ASK YOURSELF WHEN A CHILD'S BEHAVIOR IS A CONCERN:

Behavior is the child's primary means of communicating. Parents, teachers, and others close to the child need to observe the behavior in order to discover what the child is trying to say.

1. What specific behavior(s) worries you?
2. How often does this behavior happen?
3. How long has this been going on? When did it start?
4. When does this behavior happen most often?
5. Where does this behavior happen most often?
6. With whom does it happen most?
7. (a) What happens as a result of this behavior? (For example, does the behavior get alot of attention?)
   (b) What do you, and/or others, do to respond to this behavior?
8. Does this behavior fit with the child's basic personality/temperment?
9. Is this behavior normal for the child's age?
10. Does the child feel good about him/herself most of the time? frequently? sometimes? rarely?
11. How does this behavior get in the way of the child's daily functioning?
12. Does the child have any health problems which might help explain the behavior?
13. Has the child's behavior changed because things around him/her have changed? Have their been changes in the child's life or in the lives of other family members?
14. Why are you especially concerned about this behavior right now?
15. Is this behavior getting worse or better?
16. What's your guess as to why this behavior is happening?

RESOURCES - SCREENING AND ASSESSMENT

Deaconess Medical Center Physical Medicine and Rehabilitation	Penny Green 458-7246
Speech Tharpist, Physical Therapist, available to visit classroom, observe, and determine need for further evaluation.	
Spokane Guild School and Neuromuscular Center	326-1651
Diagnostic Center for developmentally delayed infants and children.	
Spokane County Health District	456-4201
Children and Youth health screening.	
CHILDFIND - Spokane Public Schools	Individual School Districts
Pre-school screening for developmental delays and learning disabilities.	
Infant Hearing Assessment Foundation	838-7162
Hearing screening and assessment.	
Hearing Clinic	458-6200
Speech and hearing tests, and speech diagnosis.	
Lion's Low Vision	328-3730
Vision exam and services.	
Dental Screening	456-2943
Dental exam for children.	
Rehabilitation Associates	624-9217
Evaluation of hyperactive and autistic children.	

RESOURCES - TREATMENT

Spokane Guild School and Neuromuscular Center 326-1651

Treatment Center for developmentally delayed infants and children.

Northwest Child Development Center 484-3470

Special education services for children 18 months to 8 years.

Cystic Fibrosis Center - Deaconess Medical Center 458-7300

Services to children with cystic fibrosis.

Diabetes Education Center - Deaconess Medical Center 458-7142

Services to children with diabetes (and their parents).

Parent / Child Resources 747-0165

Services for children with learning difficulties.

Crippled Children's Services 456-5783

Services to infants and children of families with congenital health problems.

Eastern Washington Epilepsy Medical Assistance Program 624-1033

Services to children who suffer from epilepsy.

Father Palmer Memorial Braille Services, Inc. 624-9843

Services to blind children and adults.

Spokane Deaf Center 328-9220

Services to anyone who is deaf or hard of hearing.

Hearing Impaired Infant Program 466-7583
Services to infants and young children with hearing impairments.

Community Health Nursing 456-3613
Services in child care, nutrition, parenting skills and discipline, and health assessment.

Rehabilitation Associates 624-9217
Parent training to assist with hyperactive and autistic children.

Family Home Care 838-7284
Physical therapy, speech therapy, and nursing services.

DEACONESS CHILD CARE CENTER

Consent For Health Screening

I give permission for my child _____
Child's Name

_____ _____
Birthdate Age

to receive health promotion screening services provided at Deaconess Child Care Center, including but not limited to vision, hearing, dental, developmental, speech, and behavior. Also included may be the screening services of an independent qualified observer. I will be informed of the screening results. Those individuals conducting the screenings may discuss the results with Deaconess Child Care staff. This consent is effective until revoked in writing.

Date: _____ Signature: _____
Parent or Guardian

_____
Relationship

_____
Street Address

_____
City State Zip

_____
Telephone

DEACONESS CHILD CARE CENTER

Consent For Release Of Information

I give permission for those listed below to receive information regarding my child, _____, from staff of Deaconess Child Care Center.
Child's Name

_____
Name

_____
Name

_____
Name

This consent is effective until revoked in writing.

Date: _____ Signature: _____
Parent or Guardian

_____
Relationship

_____
Street Address

_____
City State Zip

_____
Telephone

Appendix E: Survey of Effectiveness of New Evaluation Instrument and Follow-Up Procedures

In using the Center's new evaluation instrument The Lexington Developmental Scale, and in reviewing the staff manual "If A Child Is A Concern," do you feel that.....(check all that apply):

1. _____ You understand how to use the Lexington Developmental Scale.

2. _____ You fell comfortable using the rating scale to evaluate the children in your group.

3. _____ You have time to evaluate the children in your group using the scale.

4. _____ You will be able to evaluate the children in your group as frequently as is recommended. (Twice a year for pre-school and toddlers, at three month intervals for pre-tods and infants.)

5. _____ The rating scale evaluates those areas of development that you feel are important for children in your group.

6. _____ The rating scale and the staff manual would help you identify a child who might be at risk for developmental delays, learning difficulties, or behavior problems.

7. _____ The procedures/steps outlined in the staff manual would be valuable in validating your concerns about a child in your group, in seeking follow-up evaluations from other professionals, and in suggesting resources for assistance in meeting the child's needs.

Please take a few moments to complete this brief survey. No name is necessary. This information is important in evaluating the effectiveness of our new assesment instrument, The Lexington Developmental Scale, and our newly implemented plan for combining evaluation with resources to validate concerns and provide assistance in meeting children's needs. Please be frank in your responses. Add comments if you wish. Thank you for your time and input.